

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 24 181					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR Sept. 14, 1980							2b. HOUR 9 A.M.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN						
MARGARET E. COHEY					June 13, 1901		79 YRS.								
3 SEX Female		4 RACE white		8 DATE OF BIRTH MONTH DAY YEAR		9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Caroline Co. Md.		10 CITY OR TOWN OF DEATH Crumpton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Schrock's Boarding Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Queen Anne		13c. CITY OR TOWN Crumpton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Third St.							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 215 14 3924		17. INFORMANT ADDRESS Margaret N. Boyles Crumpton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one yr															
<p>4140</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe COPD for 15 yrs. with cyanosis and orthopnea.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Apr 1980 , 19 80 , to Sept 14 , 19 80 , that (I) (<input type="checkbox"/>) lost saw the deceased alive on Sept 14 , 19 80 , and that in (my) (<input type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input type="checkbox"/>) did (<input type="checkbox"/>) view the body after death.															
22b. SIGNATURE Wallace Obenshain M.D.		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9-15-80									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace G. Obenshain		22f. ADDRESS Cecilton, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/80		23c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery		23d. LOCATION CITY OR TOWN Crumpton, Md.		23e. COUNTY STATE							
24. FUNERAL DIRECTOR NAME J. Willis Wells		25. ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 17 1980		25b. REGISTRAR'S SIGNATURE Larry McReady									

and the following

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 24182
					REG. NO.
1. DECEASED NAME (TYPE OR PRINT) ELEANORA M. GRAY					2a. DATE OF DEATH MONTH DAY YEAR Sept. 25, 1980
3. SEX female		4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR March 3, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne Co. MD.
10. CITY OR TOWN OF DEATH Sudlersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kitty's Domicile (Home)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None
13a. STATE Maryland		13b. COUNTY Q. A. Chestertown	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS RFD (Kingstown)
14. FATHER'S NAME FIRST David Gray		MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST Eleanor M. Harris LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO none		17. INFORMANT Anne Gray Daly	
				P.O. Box # 344 Chestertown, Md. 21620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first { (b) DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cerebral vascular disease					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Consensual mental deficiency, type undetermined					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 78 , to Sept. 25 , 19 80 , that (I) (we) last saw the deceased alive on 9/25 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Robert W. Farr DEGREE					
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/26/80			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr		22f. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/26/80	23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory		23d. LOCATION CITY OR TOWN Wilmington, Del. COUNTY STATE
24. FUNERAL DIRECTOR NAME Willis Wells		ADDRESS Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR SEP 29 1980 25b. REGISTRAR'S SIGNATURE John McHenry		
DHMH-16 25 (VRA 15, 4) 1/79					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

Item 14 G 548 10/20/80 GB

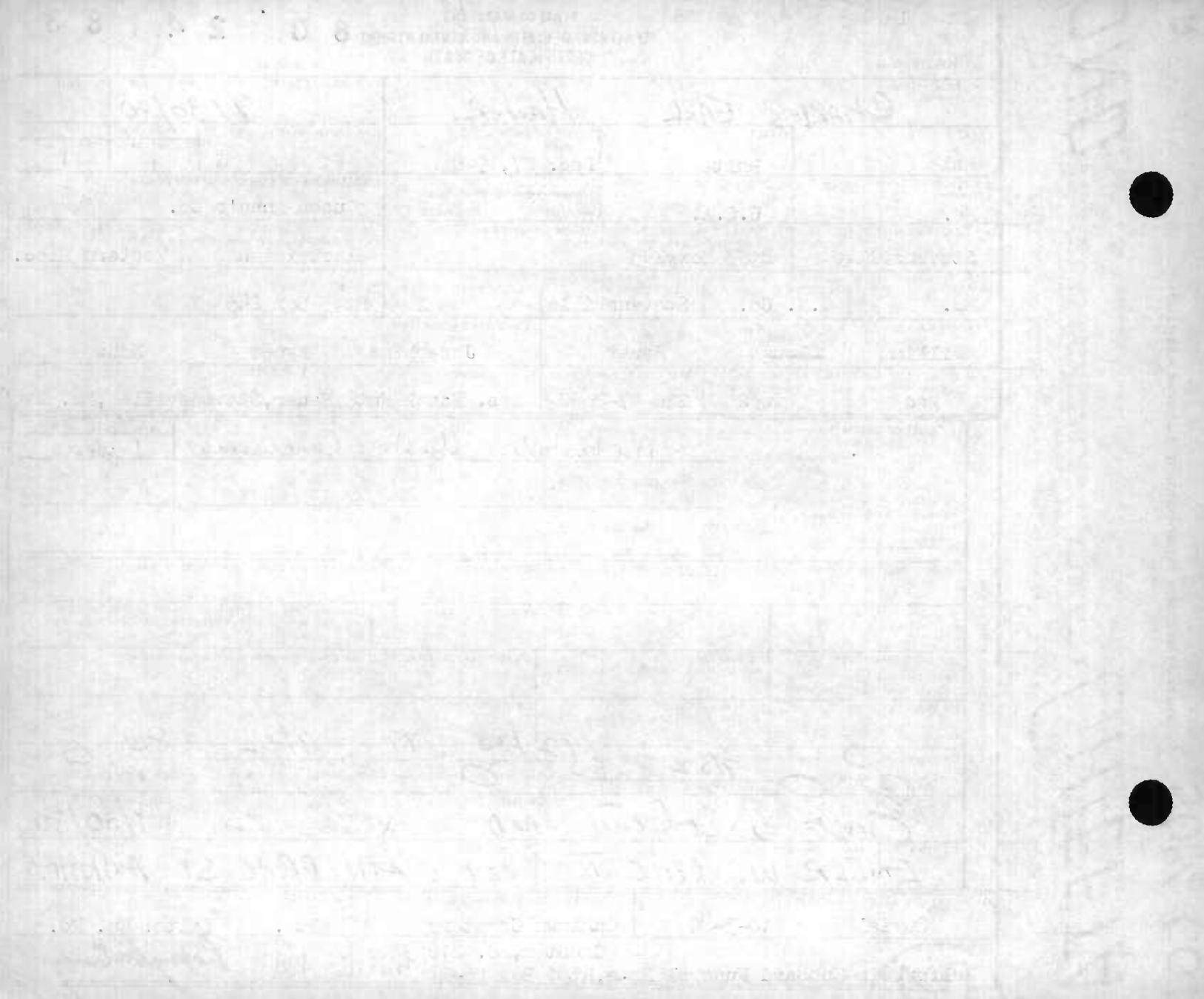
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 1 8 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>Charles Earl</i>					<i>Hauer</i>	<i>9/30/80</i>						
3. SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
				<i>Dec. 27, 1918</i>			61			M YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Queen Anne's Co.</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Stevensville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Rt#3 Box#245</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Electrician</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Western Elec.</i>				
13a. STATE <i>Md.</i>		13b. COUNTY <i>Q.A. Co.</i>		13c. CITY OR TOWN <i>Stevensville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Rt#3 Box 245</i>				
14. FATHER'S NAME FIRST <i>William</i>		MIDDLE <i>Claude</i>		LAST <i>Hauer</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Josephine</i>		MIDDLE <i>Agnes</i>		LAST <i>Nohra</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>WW#2</i>		17. INFORMANT <i>Mrs. Hazel Ruth Hauer, Stevensville, Md. 21660</i>		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))		<i>Metastatic Gastric Carcinoma</i>										
<i>1519</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>										
		DUE TO, OR AS A CONSEQUENCE OF (b)										
		DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>912</i>			21f. LOCATION STREET <i>12/30</i>		CITY OR TOWN <i>79</i>		COUNTY <i>9/30</i>		STATE <i>80</i>	
22a. I certify that (I) this hospital attended the deceased from <i>9/22</i> to <i>9/30</i> , 19 <i>86</i> , to <i>79</i> , 19 <i>86</i> , that (I) we last saw the deceased alive on <i>9/22</i> , 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Ensor W. Cole III</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/30/80</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ensor W. Cole III</i>		22e. ADDRESS <i>121 CATHEDRAL ST ANNAP.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-3-80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Oaklawn Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Balto.</i>		COUNTY <i>Balto.</i>		STATE <i>Co. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Helfenbein-Hubbard Funeral Home</i>		ADDRESS <i>Rt#1 Box 66-B Chester, Md. 21611</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 6 1980</i>		25b. REC'D. TRA'R'S SIGNATURE <i>Henry McCreedy</i>						

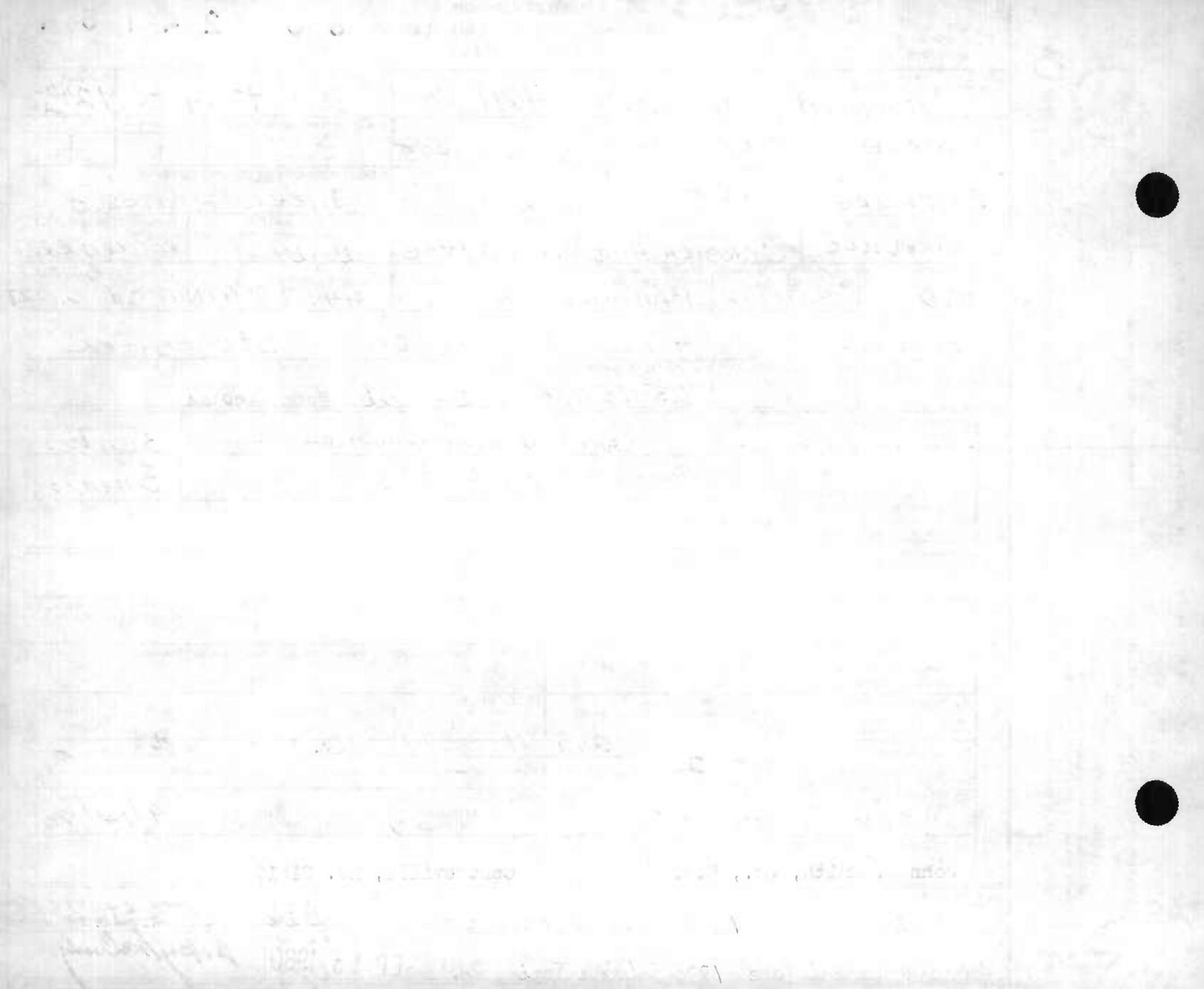


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director it should be submitted for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 24184			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Howard			Wayne	Hill		SEP 9-14-80						1242 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		Caucasian		MONTH	DAY	YEAR	85			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
BALTIMORE		USA					Queen Anne's Co. MD			CENTREVILLE					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
CORSICA Hills Nursing Home				pipefitter				RETIRED ER							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. STATE			
MD				Baltimore Co.		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4417 WALNUT Rd 21227		BAIR-			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, 1c, 1d, 1e, 1f, 1g) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no				705-05-0984				Corsica Nursing Home Records				Central Thrombosis		3 months	
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (b)				ASHD						5 years.	
				DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug. 11, 1979, to Sept 14, 1980, that (I) (we) last saw the deceased alive on Sept 12, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/14/80						
John R. Smith, Jr., M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			
burial			9/17/80			Loudon Park Cemetery			Baltimore City Maryland			STATE			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Ambrose Funeral Home			1328 Sulphur Spring Rd.			SEP 15 1980			Henry Ambrose						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212011 8 5
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Elsie E. Kibler	Middle	Last	2a. DATE OF DEATH Month 9-13-80	2b. HOUR Year 2:50 M
3. SEX female	4. RACE Cau.	S. DATE OF BIRTH 5-1-93	6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0
7. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Q.A.		
10. CITY OR TOWN OF DEATH Centreville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Corsica Hills Nur. H.	12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Caroline	13c. CITY OR TOWN Greensboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER State Rt 313	
14. FATHER'S NAME First William H. Jones	Middle	Last	15. MOTHER'S MAIDEN NAME First Margaret Duncan	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-02-1172	17. INFORMANT Elizabeth Smith	Address Greensboro, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 8113	City or Town Greensboro	County Caroline	State Md.
22a. I certify that (I) (this hospital) attended the deceased from Aug 23 , 19 79 , to Sept 13 , 19 80 , that (I) (we) last saw the deceased alive on Sept 10 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. R. Boudinot Jr.</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/15/80	
22d. PHYSICIAN'S NAME (Type) John R. Smith Jr.	22e. ADDRESS Centreville, Md 21617				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-16-80	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Cross Cemetery, Greensboro, Caroline Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>John E. Boudinot</i>	25a. FILED BY REGISTERED MAIL Sept 13, 1980	25b. REGULAR SIGNATURE <i>John E. Boudinot</i>			

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REBELLION

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See notes section

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ANSWER TO THIS

George H. Martin

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Quality Date-00 Hot Cross Cinnamon Cloves 100g

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 4 G 548 10/27/80 GB
Items 21a-21f & 22a G540
FOR
1 - STATE 11/5/80 dad
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 0 2 4 1 8 6

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
				Elsie	S.	Morgan	9-27-1980				5:05 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
F		White		7 14 1892			88							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Centreville MD.				
Delaware USA		USA					Queen Anne's Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Centreville		Corsica Hills Nursing Home		housewife			none							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Caroline		Goldsboro			none			Larrimore				
14. FATHER'S NAME FIRST		J. B. Smith		15. MOTHER'S MAIDEN NAME Susie										
Goldsborough		Smith												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, OR UNKNOWN)		(YES, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no				220-34-7509			Wilson Smith			Goldsboro, Md.			5 years	
<p>18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF <u>a. s. N. S.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF <u>Fracture left hip</u> (c) _____</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. unknown 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		unknown					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none					21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
									Goldsboro, Md.					
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1970</u>, to <u>Sept. 27, 1980</u>, that (I) <input type="checkbox"/> lost saw the deceased alive on <u>Sept. 20, 1980</u> Natural death. My opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.</p>														
22b. SIGNATURE <u>J. B. Smith</u>		22c. DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>9/21/80</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John R. Smith Jr.</u>		22f. ADDRESS <u>Centreville, Md.</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-30-80		23c. NAME OF CEMETERY OR CREMATORIAL Greensboro			23d. LOCATION CITY OR TOWN		23e. COUNTY			STATE		
Burial							Greensboro					Caroline Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS <u>John E. Boulais</u>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Kathy McNeely</u>					
		Greensboro, Md.					Oct 1 1980							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 24187		
1- STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR				
Benjamin		J.	Nichols				9 6 1980			M				
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			
Male		Black	12 03 1906		73 yrs.						9 6 1980			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County						
Maryland		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Little Creek Landing									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator Revere Coppe			
Centreville														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 200 Winters Lane				12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		BA Ho		Catonsville										
14. FATHER'S NAME FIRST		MIDDLE	LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			Unknown		
Eugene			Nichols			Jennie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS							
NO		214-01-5996			Roberta Nichols		200 Winters Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?		
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY) Margarita A. Korell, M.D. Assistant MEDICAL EXAMINER											DATE SIGNED 9-7-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9-12-80		23c. NAME OF CEMETERY OR CREMATORIAL Western Star Cemetery			23d. LOCATION CITY OR TOWN Baltimore County, Md.		COUNTY		STATE			
Burial														
24. FUNERAL DIRECTOR		ADDRESS Herbert E. Nutter 3035-37 W. North Ave SEP 9 1980												
		REGISTRAR'S SIGNATURE <i>Patsy Nutter</i>												
BP		DHMH - 17 (VR A15 ME (5)) 15M 7/76												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

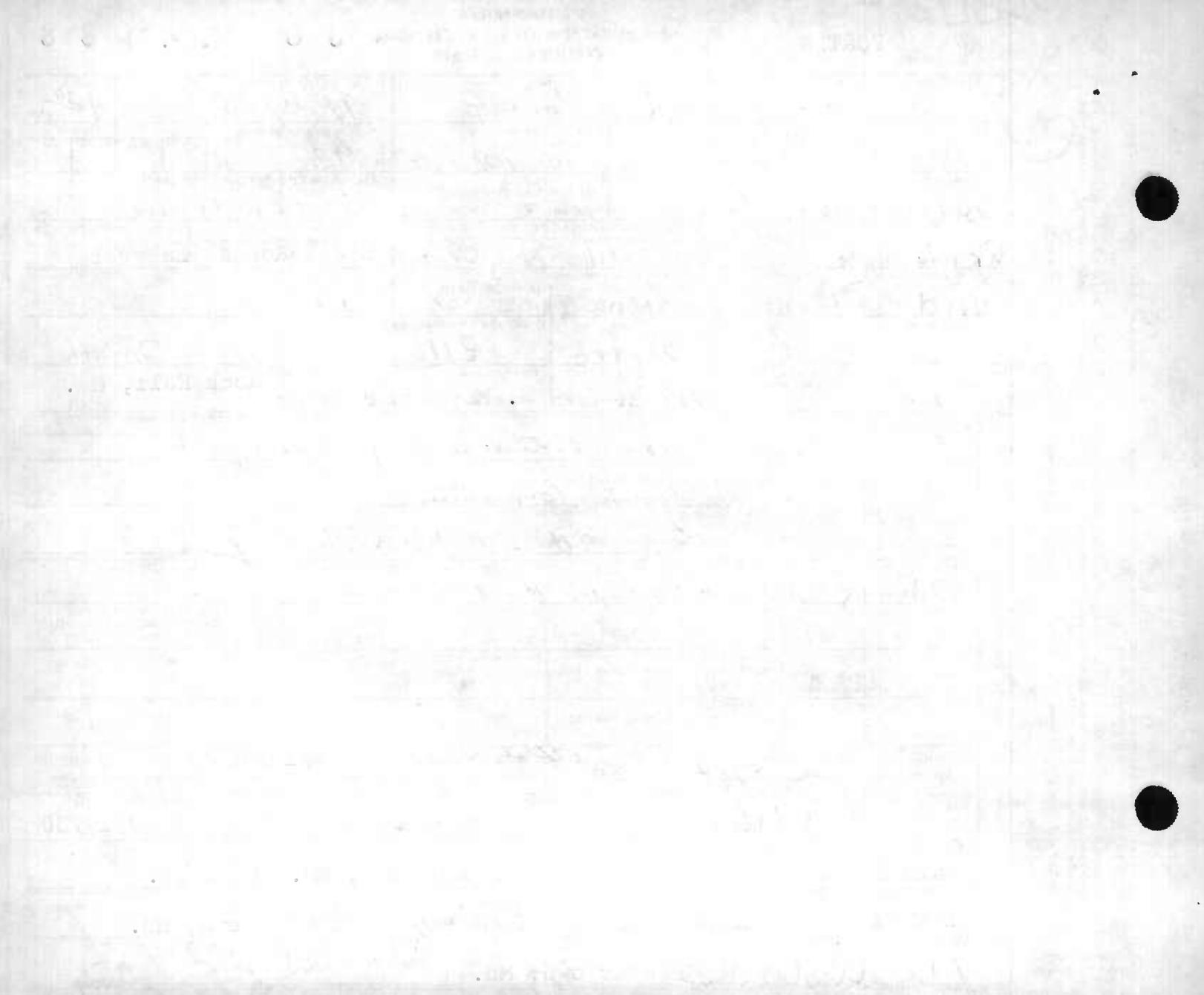
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 24188			
					REG. NO.			
1. FOR STATE REGISTRAR	PORTER							
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
William Lloyd Porter				9/18/80				4:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR
Male	White Caucasian	MONTH DAY YEAR	10 12 1886	93	YRS.	MONTHS	DAYS	IF UNDER 24 HRS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH						
Queen Anne	USA	Queen Anne						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Centerville	Corsica Hills Nsg Center			State Roads	Laborer			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
Md	Kent	Galeana		Rt 213				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	MIDDLE	LAST		
William T. Porter				Ella		Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					
No	219-36-6163	W. Maynard Poreter	Rock Hall, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Chronic Obstructive lung disease								
515- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Bronchitis								
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Extensive Fibrosis of lung								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
(1) Senility		(2) arteriosclerotic Heart disease						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 10, 1979, to 9/18/80, 19, that (I) (we) last saw the deceased alive on 8/12/80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE K. K. Kullman	DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED 9/19/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin Kue Wun	22e. ADDRESS Chestertown, Md. High St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/21/80	23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE			
24. FUNERAL DIRECTOR NAME J. Willis Wells	ADDRESS Chestertown, Md.	25a. DEED, BY REGISTRAR SEP 24 1980	25b. REGISTRAR'S SIGNATURE Robert McRandy					

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30 24189
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 19 M		
Mary Virginia Shaffer						<input type="checkbox"/>						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 9 25 19 80 M		
Female	White	12-18-1914	65 yrs.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's Co. MD.							
Virginia	USA											
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Stevensville	at her home					housewife						
13a. STATE Md.	13c. CITY OR TOWN Queen Anne's	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Stevensville Md. 21666							
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Elizabeth Haynie			MIDDLE	LAST	Walker				
Alpheus		Haynie										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT Albert V. Spies, Jr.			ADDRESS Rt. #1 Box F 28 Greensboro Md.							
no	215-10-3585											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>A. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>CHRONIC</u> <u>Remote</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Chronic Alcohol Use</u>												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY P.M.	HOUR A.M.	MONTH	DAY	YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
TITLE (SPECIFY) M.D. <u>Ralph S. Libby</u> , ASSISTANT MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Dr. Ralph Libby												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9-29-80			23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery			23d. LOCATION CITY OR TOWN Easton			
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home			ADDRESS Chester, Md. 21618			25a. DATE REC'D. BY REGISTRAR OCT 1 1980			25b. REGISTRAR'S SIGNATURE <u>Ralph S. Libby</u>			
DHMH - 17 (VR A15 ME (5)) 30M 7/73												



FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS

301 W. PRESTON STREET, BALTIMORE, Md. 21201

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. File pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

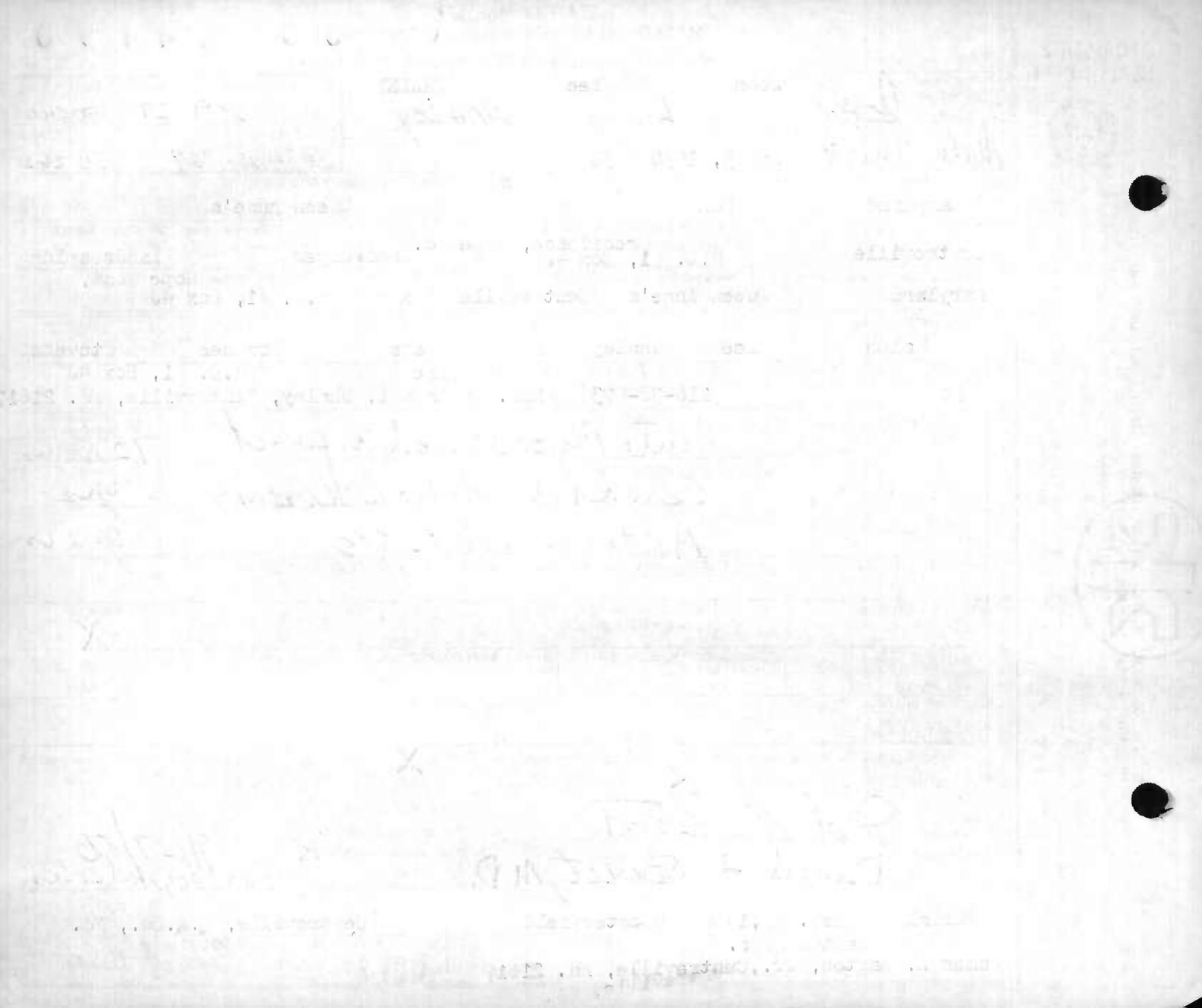
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 2, and 3 to the funeral director. Page 5 may be retained for your files.

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24190

1. DECEASED NAME (Type or Print)	First John	Middle Lee	Last WHALEY	20. DATE KNOWN <input type="checkbox"/> Month Doy Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9 27 1980 000 M	2b. HOUR 000 M
3. SEX Male	4. RACE white	S. DATE OF BIRTH May 3, 1930	6. AGE (in years lost birthday) 50	IF UNDER 1 YEAR MONTH DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year September 27 1980 230AM
7b. CITIZEN OF WHAT COUNTRY? Maryland	USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Queen Anne's	12b. KIND OF BUSINESS OR INDUSTRY Landscaping	
10. CITY OR TOWN OF DEATH Centreville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) residence, Hope Rd R.D. #1, Box 4J			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Landscaper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) Maryland	13b. COUNTY Queen Anne's	13c. CITY OR TOWN Centreville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Hope Road, R.D. #1, Box 4J	
14. FATHER'S NAME Ralph	First Lee	Middle Whaley	15. MOTHER'S MAIDEN NAME Sara	Middle Frances	Last Stevens
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 216-38-9736	17. INFORMANT Wife Mrs. Barbara L. Whaley, Centreville, Md. 21617	ADDRESS R.D. #1, Box 4J		
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b) and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarct Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Arteriosclerosis					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours yrs years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>David A. Stout</i> EXAMINER'S NAME (Type) David A. Stout, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Easton, Md 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sep. 29, 1980	23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield	23d. LOCATION (City or Town) Centreville, Q.A. Co., Md.	(County) (State)
24. FUNERAL DIRECTOR Barton Bros.		ADDRESS James H. Barton, Jr., Centreville, Md. 21617	25a. REC'D BY REGISTRAR DATE OCT 3 1980	25b. REGISTRAR'S SIGNATURE <i>Patsy McNeely</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 24191					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21b. HOUR					
Charles Wright						7-22-80				7:22 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M		B		MONTH	8	DAY	2	YEAR	1892	87	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.								Queen Anne's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chester		Cox Neck Rd		Retired											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		QA.		Chester		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Cox Neck Rd.							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	ADDRESS					
		Charles		Wright	Emman Wright					Chester Cox Neck Rd. Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		212-12-2444				IMMEDIATE CAUSE (a)		CARDIOVASCULAR ACCIDENT		2 mo.					
4292		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) ASC.V.D.		(c)				Remote					
DUE TO, OR AS A CONSEQUENCE OF															
DUE TO, OR AS A CONSEQUENCE OF															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7-21-77 to 7-22-80, that (I) (we) last saw the deceased alive on 7-21-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
Ralph E. Libby, M.D.		MD				8-28-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		GRASONVILLE, MD. 21638											
Ralph E. Libby, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SELECT ONE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE						
Burial		7/26/80		Chester		Grasonville			Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF CERTIFICATION		25b. RECEIVED FOR SIGNATURE									
Bill Donnell P.O. Box 606 Easton				SEP 18 1980											

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